FBMC
Premier Benefits Solutions

Claim Form
for FSA, HRA and the Payment Card

USE ONLY BLACK INK

PLEASE READ THE INSTRUCTIONS ON THE BACK PRIOR TO COMPLETION.
KEEP A COPY OF THIS FORM FOR YOUR RECORDS. SEND COPIES OF ORIGINAL RECEIPTS.

PERSONAL DATA

Name: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

SS#, Employee or FBMC ID Number: _____ Employer: _____ Day Time Phone: _____

☐ **PLEASE CHECK HERE IF THIS IS A NEW ADDRESS.**

I understand, agree and certify to the following:

- I will use my FSA/HRA to only pay for IRS-qualified expenses, permitted under my Employer's plan(s), provided to me and my IRS-eligible dependents, on the date(s) indicated below as being incurred within my period of coverage under the applicable plan year.
- I will request reimbursement only after the services have been provided.
- I have not and will not seek reimbursement through any other source, and will exhaust all the other sources of reimbursement, including those provided under my Employer's plan(s), before seeking reimbursement from my FSA or HRA.
- I specifically release my Employer and FBMC from any liability resulting from either my participation in any FSA/HRA or for any misrepresentation I make regarding my requests for reimbursement.
- I have read and understand the information on the front and back of this form.
- If I participate in my Employer's Dependent Care FSA Plan, I will file a Form 2441 with my income tax return and provide any taxpayer identification number required.
- The dependent care expenses I submit for reimbursement were incurred to allow me and my spouse (if married) to work or actively look for work.

Participant's Signature: _____ **Date:** _____

(Required to process claim/reimbursement)

PAYMENT TYPE *Place a check mark [✔] in the box(es) and fill in claim amount of any that apply below (**Medical FSA** or **HRA** expenses ONLY):*

A. ☐ I used the FBMC payment card to pay for these expenses - must attach documentation for transactions requiring documentation .† $_____

B. ☐ Please pay me for these out-of-pocket expenses - documentation must be attached.† $_____

C. ☐ Please apply attached documents as substitution toward card transactions requiring documentation.
For lost documentation or substantiation of an ineligible charge † $_____

MEDICAL FSA OR HRA *Fill out completely* (use for eligible medical expenses for yourself and qualifying dependents)

CHECK (✔) PAYMENT TYPE: A. Card	B. Pay me	C. Sub. docs.	Name of Person Receiving Service	Relationship to Employee	Provider of Services*	SERVICE DATE:** FROM:	TO:	AMOUNT THAT IS YOUR RESPONSIBILITY
☐	☐	☐						$
☐	☐	☐						$
☐	☐	☐						$
☐	☐	☐						$
☐	☐	☐						$
							TOTAL THIS PAGE	$ 0.00
							GRAND TOTAL FOR MULTIPLE PAGES	$

DEPENDENT CARE FSA *Fill out completely* (use for childcare, dependent care and elder care services)

Name of Person Receiving Service	Relationship to Employee	Age and Grade	Name and Address of Persons or Facility Providing Service	SERVICE DATE:** FROM:	TO:	AMOUNT OF REIMBURSEMENT
						$
						$
						$
					TOTAL THIS PAGE	$ 0.00
					GRAND TOTAL FOR MULTIPLE PAGES	$

SIGNATURE OF DAY CARE PROVIDER (LISTED ABOVE)
OR ATTACH STATEMENT / BILL : _____

† Please remember to keep copies for your records.
* "Provider of Services" means hospital, doctor, dentist, drugstore, medical supply store, etc.
** "Service date" refers to dates service was PROVIDED or available for pickup, not the date you paid or were charged for it.

FBMC
Mail to: P.O. Box 1800, Tallahassee, Florida 32302-1800
Toll-Free Fax to: **1-888-800-5217**
Customer Service: 1-800-342-8017 Interactive Benefits Information Line: 1-800-865-3262

IMPORTANT INFORMATION FOR REIMBURSEMENT

(TO AVOID DELAYS, PLEASE READ THESE INSTRUCTIONS CAREFULLY.)

IMPORTANT REQUIREMENTS & INFORMATION (not following these requirements may cause your claim to be rejected)

- Complete all lines in the Personal Data Section.
- Use black ink only.
- Do not use highlight markers on your claim form or documentation (we scan all documents).
- Your FBMC ID # can be obtained on our web site at **www.myFBMC.com** after login.
- Submit copies of invoices, statements, bills, receipts, or EOB in the same order as listed on the claim form.
- Credit card receipts and canceled checks cannot be used to approve your claim.
- Account holder must sign and date the claim form.
- More forms are available at **www.myFBMC.com**.
- Attach additional sheet for more items/lines.
- Retain a copy of your claim form(s) and all documentation for your records.

DOCUMENTATION REQUIREMENTS:

Medical Flexible Spending Account (MFSA) or Health Reimbursement Arrangement (HRA) documentation must include the following:

- Date service(s) were received (not necessarily same as date paid)
- Your cost for the service(s). Total amount that is your responsibility.
- Type of Service(s) (x-ray, office visit, prescription drug name or over-the-counter item etc.)
- Name of person receiving services (this must be the account holder, spouse, or IRS eligible dependent).
- An EOB can be submitted for in lieu of a statement or bill.
- HRAs - you must submit an EOB for any medical services received. See enrollment guide for any additional filing requirements.

Orthodontics – The following is required:

- A written statement from the treating dentist/orthodontist showing the type and date the service incurred, the name of the eligible individual receiving the service and the cost for the service and
- A copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Note: Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed.

Dependent Care Flexible Spending Account (DCFSA)

- If the personal data section and the dependent care section are completed in their entirety and the form has been signed by yourself and your day care, no further documentation is needed.
- In lieu of the provider signature, you can submit a statement, invoice or bill that shows the name and address of the provider, beginning and ending dates of the provided services, the cost of service(s), and the name of the eligible dependent(s).
- Claim requests for multiple months will be prorated and itemized based on the number of months listed. Payment will be issued after the end of each month for which services were incurred, based on the available balance in your account.
- Educational expenses incurred for a child in kindergarten and up are not reimbursable. The cost of dependent care before and after school is reimbursable.
- Expenses such as tuition, registration fees, activity fees, books, supplies and meals are not reimbursable.

Special Requirements – In addition to the documentation noted above, some services require additional documentation such as a Letter of Medical Need, a Capital Expense Worksheet, or a Personal Use Statement. Please visit **www.myFBMC.com** for copies and description of use.

Toll-Free Fax to: 1-888-800-5217

Mail to: Fringe Benefits Management Company (FBMC), P.O. Box 1800, Tallahassee, FL 32302-1800
Interactive Benefits Information Line: 1-800-865-3262

Visit **www.myFBMC.com** for frequently asked questions, account balances, documentation requirements for card transactions, and forms.